



## Continuation Guidance – Budget Year Four Attachment X Cross-Cutting Activities

Public health emergency preparedness requires that state and local health departments, hospitals, and other health care entities be able to mount a collective response featuring seamless interaction of their event-specific capabilities. For example, while public health departments would play the predominant role in a public health emergency requiring mass distribution of vaccine or antibiotic prophylaxis, hospitals and other health care entities would carry the primary burden in the wake of a mass casualty incident.

Many aspects of public health emergency preparedness demand a unifying jurisdiction-wide strategy. For this reason, the Department of Health and Human Services (HHS) directs both the CDC and the HRSA cooperative agreements primarily to state health departments and looks to the senior state public health official to effect the necessary integration of pertinent activities. The scope of this integration must be both vertical (i.e., between state and local activities) and horizontal (i.e., between public health and healthcare activities).

In addition, public health emergency preparedness activities should be coordinated closely with those of public safety and emergency management agencies, especially with respect to activities funded by the Department of Homeland Security and/or other federal agencies. States should actively support efforts by counties and municipalities to enhance their readiness for public health emergencies, including their capacity to rapidly accommodate state and federal assets (such as the Strategic National Stockpile) and emergency response teams (such as those provided by the National Disaster Medical System).

To ensure that all preparedness activities are coordinated and integrated at the state and local levels, applicants should address cross-cutting issues that are identified below (Sections A through F). The Recipient Activities in Sections A through E consist of two subsections beginning with the following phrases:

- 1 - Provide the following information.
- 2 - Carry out the following activity.

The responses to all subsections 1 as well as to Section F should be assembled as one, stand-alone document. Responses to subsections 2 should be integrated and interwoven with descriptions of activities in the corresponding Priority Area.

This Cross-Cutting Activities section is identical in both the CDC and the HRSA guidance. In the HRSA guidance, this section appears in the body of the guidance as Part A; in the CDC guidance, it appears as Attachment X. **Responses to this section should be identical whether submitting for CDC or HRSA funding.** Thus the responses need be prepared only once and copies inserted in the separate submissions to CDC and to HRSA.



## A. **CROSS-CUTTING BENCHMARK #1: INCIDENT MANAGEMENT**

This benchmark is intended to help states and local governments prepare for their eventual participation in the National Incident Management System (NIMS), which is prescribed in Homeland Security Presidential Directive #5 (HSPD-5). NIMS is to cover all incidents (natural and unnatural) for which the federal government deploys emergency response assets. The Secretary of Homeland Security is responsible for leading the development and implementation of NIMS. Additional information is included in the Addendum at the end of this document.

During the upcoming budget period, the Department of Health and Human Services will undertake the following activities with respect to NIMS:

- Collaborate with the Department of Homeland Security and other agencies of the Federal Government in developing NIMS, as prescribed by HSPD-5.
- At appropriate times, share NIMS-related documents with cooperative agreement recipients and invite their comments with a view to keeping them apprised of progress toward and enlisting their assistance in NIMS development.

### RECIPIENT ACTIVITIES:

1. Provide the following information (not to exceed 5 pages). Describe the roles and responsibilities of public health departments and the hospital community (including their supporting health care systems) related to incident management at the state and regional levels – including inter-state as well as intra-state regions, as appropriate.
  - a. Does your state (city) currently have an incident management system? If yes, please indicate a web-site address or other reference to a descriptive document and answer the following questions about the system.
    - i. What government agencies participate in the system?
    - ii. What other entities, public and private, participate in the system?
    - iii. Which agency has responsibility for overall planning, directing, and coordinating jurisdiction-wide response operations?
    - iv. For what classes of incidents does the public health department have lead responsibility for planning, directing, and coordinating jurisdiction-wide response operations?
  - b. Has your state government defined intra-state regions to facilitate planning and conduct of incident management? If yes, please provide a map showing the regional structure.
  - c. Does each intra-state region have an incident management plan? If yes, please indicate a web-site address or other reference to a typical plan.
  - d. Summarize the results of activities during the FY2002 budget period to achieve CDC Critical Benchmarks 3, 5, 6, and 12 and HRSA Critical Benchmark 3; and describe how these results relate to the statewide and regional incident management systems.



2. Carry out the following activity during the upcoming budget period:

- a. Review and comment on DHHS-furnished documents regarding NIMS as it undergoes development.
- b. Develop and keep up to date a description of the roles and responsibilities of public health departments, hospitals, and supporting health care systems in the statewide incident management system and, where applicable, in regional incident management systems.

The estimated costs for this activity are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements. For the estimated costs assigned to the CDC cooperative agreement, specify them in the budget for Focus Area A and discuss them in the associated budget justification.

**B. CROSS-CUTTING BENCHMARK #2: JOINT ADVISORY COMMITTEE FOR CDC AND HRSA COOPERATIVE AGREEMENTS**

Establish and operate an Advisory Committee to assist the jurisdiction's senior public health official in overseeing both the CDC and HRSA Cooperative Agreements

DHHS strives to ensure that the CDC and HRSA cooperative agreements are complementary with respect to strategy and scope and feature mutually reinforcing provisions. Moreover, DHHS strives to foster appropriate integration of CDC- and HRSA-funded activities by directing both cooperative agreements to the jurisdiction's health department and by synchronizing the application, review, and award processes for the two cooperative agreements.

The CDC and HRSA cooperative agreements awarded in fiscal year 2002 each called for formation of an advisory committee to help guide their respective funded activities. As part of the FY 2003 cooperative agreements, with a view to enhancing integration of public health department and hospital community initiatives, DHHS is calling for formation of a single advisory committee to assist the senior public health official in overseeing both the CDC and the HRSA cooperative agreements. The transition from two committees to one may occur any time during the upcoming budget period. **The unified committee may include CDC- and HRSA-specific subcommittees, among others, if the recipient so chooses.**

RECIPIENT ACTIVITIES:

1. Provide the following information (not to exceed 2 pages). Describe the activities of the advisory committees for the CDC and HRSA cooperative agreements during the FY2002 budget period (CDC Critical Benchmark #2 and HRSA Critical Benchmark #2). Summarize the major accomplishments. Identify the areas, if any, where the committees' results fell short of expectations and discuss the obstacles encountered and potential ways to overcome them in the future.



2. Carry out the following activity during the upcoming budget period: Establish an Advisory Committee to assist the jurisdiction's senior public health official in overseeing both the CDC and HRSA cooperative agreements. Opportunities for joint or coordinated activities between public health departments and the hospital community should receive special attention. The Committee should meet at least quarterly and maintain a record of its major decisions and other actions.

The membership of the Advisory Committee should be broadly representative of public and private entities that have a significant role in preparedness for and response to bioterrorism and other public health emergencies. Representatives from the following entities must be included on the unified advisory committee and/or its subcommittees:

- State, territorial or municipal health department
- Local health departments
- State or territorial hospital association
- State or territorial mental health agency
- Academic Health Centers
- Other tertiary care centers
- Community hospitals
- Community health centers
- Primary care associations
- Clinical professional societies
- American Indian or Alaska Native health care facilities
- Veterans Administration health care facilities
- Military treatment facilities (if applicable)
- State or territorial office of rural health
- State, territorial or municipal emergency medical services director or designee
- State, territorial or municipal emergency management agency
- Local emergency medical systems
- Poison control centers
- Metropolitan Medical Response Systems
- State Maternal-Child Health Advocate
- State Trauma Coordinator
- Police departments
- Fire departments
- Red Cross and other voluntary organizations
- Consumer representatives

The Advisory Committee's members - and, if applicable, its consultants - collectively should have expertise and experience in the following professional disciplines:

- Public health (especially infectious disease epidemiology and clinical laboratory science)



- Medicine (especially emergency medicine, family medicine, internal medicine, pediatrics, critical care, infectious disease, toxicology, radiation medicine and trauma surgery)
- Nursing (especially emergency, critical care, occupational and school health)
- Pharmacy
- Hospital administration
- Hospital engineering
- Laboratory science
- Mental health (care delivery and psychological consequences of terrorism)
- Emergency medical technicians or paramedics
- Information systems and technology
- Public affairs (especially risk communication)

The estimated costs for this activity are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements. For the estimated costs assigned to the HRSA cooperative agreement, specify them in the budget for Priority Area 1 and discuss them in the associated budget justification.

**C. CROSS-CUTTING BENCHMARK #3: LABORATORY CONNECTIVITY:**

Establish operational relationships among the various types of analytical laboratories within the jurisdiction (and other jurisdictions as appropriate) that are relevant to preparedness for and response to bioterrorism and other public health emergencies.

Given the myriad forms that terrorism might take, emergency preparedness requires not only a variety of different types of analytical laboratories but also well defined operational relationships among them – especially with respect to routing of samples and sharing of test results. The jurisdiction’s senior public health official should be able to obtain analyses and associated data from any and all relevant types of analytical laboratories as needed to counter a bioterrorism incident or other public health emergency.

The classes of analytical laboratories that seem particularly relevant to bioterrorism and other public health emergencies include public health department laboratories, hospital laboratories, food testing laboratories, veterinary laboratories, and environmental testing laboratories. Collectively, such an array of laboratories should be able to test for terrorism-related pathogens and chemicals in human clinical specimens (typically, blood or urine samples), food specimens, animal specimens (including those from wildlife), and environmental samples.

Moreover, such an array of laboratories should be able to provide analyses during both the peri-event phase and the post-event phase as needed. “Peri-Event” refers to the minutes, hours, or days during which an emergency incident is unfolding. “Post-event” refers to the days, weeks, or months following an emergency incident. The duration of these phases necessarily will differ from case to case – and the phases may overlap –



depending upon the agent and medium involved and the extent and duration of human and/or animal exposure.

This Cross-Cutting Critical Benchmark relates directly to laboratory-related activities included in CDC Focus Areas C and D and in HRSA Priority Area #4. Note that collaborations with food regulatory laboratories and/or development of food testing capabilities within public health department laboratories are eligible for support under the CDC cooperative agreement because food is being recognized increasingly as a medium for biological or chemical terrorism. The Food and Drug Administration (FDA) will collaborate with CDC in integrating food safety considerations into state and local public health emergency preparedness and response. In addition, collaboration with environmental (biological) laboratories is emphasized because CDC and the Laboratory Response Network are important contributors, along with the U.S. Environmental Protection Agency and the Department of Homeland Security, to the recently announced Presidential initiative called BioWatch – a national program to monitor air at selected sites across the nation for the presence of pathogens that might be used in terrorist acts against the U.S. Homeland.

RECIPIENT ACTIVITIES:

1. Provide the following information (not to exceed 2 pages). Describe the progress made during the FY2002 budget periods of the CDC and HRSA cooperative agreements in establishing linkages between public health department laboratories (especially those of local public health departments) and hospital-based clinical laboratories (CDC Critical Benchmark #10).
2. Carry out the following activity during the upcoming budget period:
  - a. Compile a jurisdiction-wide or region-wide inventory of all the analytical laboratories that could play an important role in helping public health officials respond to bioterrorism or other public health emergencies. Include laboratories of academic health centers that have a formal affiliation with public health departments or hospitals.
  - b. Determine what cooperative arrangements currently exist between and among these laboratories and assess needs for improvements.
  - c. Consider the results of this needs assessment when planning and implementing (a) enhancements to public health department laboratories, hospital-based laboratories, and food laboratories affiliated with state or local government – including collaborating academic health centers and (b) new or improved cooperative arrangements between and among laboratories listed in the jurisdiction-wide inventory.

The estimated costs for this activity are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements. For the estimated costs assigned to the CDC cooperative agreement, specify them in the budget for Focus Areas A, C, or D as applicable and discuss them in the associated budget justification.



**D. CROSS-CUTTING BENCHMARK #4: LABORATORY DATA STANDARD.**

Adopt the Logical Observation Identifiers Names and Codes (LOINC), where applicable, as the standard codes for electronic exchange of laboratory results and associated clinical observations between and among clinical laboratories of public health departments, hospitals, and other entities, including academic health centers, that have a role in responding to bioterrorism and other public health emergencies.

Adoption of and adherence to data standards can do much toward ensuring effective and efficient response to bioterrorism and other public health emergencies. On March 31, 2003, the Secretaries of Health and Human Services, Defense, and Veterans Affairs announced their joint adoption of the first set of uniform standards for electronic interchange of clinical health information ([www.hhs.gov/news](http://www.hhs.gov/news)). Extension to the Laboratory Response Network and related laboratories is an important next step.

Additional information about LOINC and its relationship to other data standards can be found at [www.loinc.org](http://www.loinc.org). During the course of the upcoming budget period, CDC will provide technical assistance regarding implementation of LOINC and, along with the Office of the Secretary, HHS, will participate in collaborative efforts to refine and extend the codes as necessary to meet the needs of public health emergency preparedness.

**RECIPIENT ACTIVITIES:**

1. Provide the following information (not to exceed 2 pages). Describe the experiences of the recipient's public health department laboratory – and those of local public health department laboratories, as applicable – during the current budget period in promoting effective and efficient electronic exchange of clinical laboratory results and associated clinical observations.
2. Carry out the following activity during the upcoming budget period:
  - a. Adopt and implement LOINC as the standard for electronic exchange of clinical laboratory results and associated clinical observations between and among public health department laboratories, hospital-based laboratories, and other entities, including collaborating academic health centers, that have a major role in responding to bioterrorism and other public health emergencies.
  - b. In connection with CDC-provided technical assistance, identify areas where refinement or extension of LOINC would enhance public health emergency preparedness.

The estimated costs for this activity are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements. For the estimated costs assigned to the CDC cooperative agreement, specify them in the budget for Focus Area C and discuss them in the associated budget justification.



- E. CROSS-CUTTING BENCHMARK #5: JOINTLY FUNDED HEALTH DEPARTMENT / HOSPITAL ACTIVITIES.** Develop and maintain a database displaying activities funded jointly by the CDC and HRSA cooperative agreements and, as applicable, other sources.

Full preparedness for the myriad forms of terrorism requires integration of activities funded by different sponsors with different but related objectives. The President and the Congress have provided – and continue to provide – extraordinary funding through DHHS and other agencies of the federal government for enhancing state and local preparedness for acts of terror against the U.S. homeland. Demonstrating that these funds are used effectively and efficiently and in highly coordinated ways is an essential element of accountability.

This section of the guidance focuses on preparedness initiatives that involve various combinations of joint funding from the CDC and HRSA cooperative agreements and, as applicable, other sources as well. In this context, “other sources” includes: a) other DHHS-sponsored programs — such as Public Health Preparedness Centers (CDC), the Bioterrorism Training and Curriculum Development Program (HRSA), and the Medical Reserve Corps (Office of the Surgeon General); b) other agencies of the Federal Government — such as the Federal Emergency Management Agency and other components of the Department of Homeland Security; c) States or local governments; and d) foundations and other private-sector organizations.

The database need not be limited to intra-State activities. HHS encourages applicants to enter into inter-State and trans-national preparedness initiatives as they see necessary — i.e., collaborations with other applicants for the CDC and HRSA cooperative agreements and, where pertinent, with bordering Canadian Provinces and Mexican States. In particular, HHS encourages applicants to forge multi-jurisdictional partnerships where major metropolitan areas or extensive rural regions span portions of two or more States or sit astride an international border, including federal lands within Indian reservations.

**RECIPIENT ACTIVITIES:**

1. Provide the following information (not to exceed 2 pages). List the preparedness initiatives during the current budget period that are receiving joint funding from the CDC and HRSA cooperative agreements. Where funding from one or more other sources is involved as well, identify the source(s).
2. Carry out the following activity during the upcoming budget period: Maintain and extend as appropriate the database developed for the application in a form that can be included readily in progress reports or provided in response to special requests from the project officer.

The estimated costs for this activity are eligible for inclusion, with an appropriate distribution, in both the CDC and HRSA cooperative agreements. For the estimated costs



assigned to the CDC cooperative agreement, specify them in the budget for Focus Area A and discuss them in the associated budget justification.

## F. OTHER CROSS-CUTTING ACTIVITIES

Responses to each issue below need not be more than a page in length (single-spaced) but they should provide sufficient details about the nature and extent of the coordination and integration activities to permit an assessment of the adequacy of such activities. If efforts have been undertaken in any of the areas identified below, provide a brief summary of progress to date. If responses to any of the issues below duplicate information that will be provided in the CDC or HRSA specific sections of your application, you may use the same (or some of the same) text in both places.

*Surveillance.* Describe how the state health department will integrate disease surveillance systems at the state and local levels, including hospital-based surveillance systems, so that relevant data on disease reporting is rapidly captured and analyzed. Surveillance systems should be developed with a view towards capturing and reporting information in “real-time.” Systems should eventually allow for electronic communication between hospitals and public health departments at all levels.

*Coordination with Indian Tribes.* Provide more complete documentation of Indian tribal government participation in state and local preparedness planning. Describe how their participation in planning and implementation efforts will be assured by your plan.

*Populations with Special Needs.* Describe activities that will be implemented to meet the specific needs of special populations that include but not limited to people with disabilities, people with serious mental illness, minority groups, the non-English speaking, children, and the elderly. Consider all operational and infrastructure issues as well as public information/risk communication strategies. Such activities must be integrated between the public health and the hospital communities.

*Planning for Psychosocial Consequences of Bioterrorism and Other Public Health Emergencies.* Describe how the state health department is working with hospitals, mental health providers, and public and private emergency response and social services entities in planning to meet the peri- and post-event psychosocial needs of victims, those at risk, their families, psychological casualties both with and without medical illness, and emergency responders (including healthcare personnel, public health professionals, EMT’s etc.).

*Education and Training.* Describe what the health department is doing to train or ensure training of its staff and those in hospitals, major community health care institutions, emergency response agencies, public safety agencies, etc.) to respond in a coordinated manner in the event of a bioterrorist attack or other public health emergency. Describe plans (including joint exercises and drills) that will ensure that each category of personnel



in these organizations/agencies knows what their duties are, what is expected of them, and with whom they will be interacting in such an event.

*Involvement of Academic Health Centers.* Recognizing that academic health centers constitute institutions with expertise and resources in health care delivery (often with emergency response/trauma care capabilities), education/training and research, state and local health departments should capitalize on these assets, if available in their regions, in their preparedness efforts. Describe any activities underway or planned that will involve nearby academic health centers.

*Interoperability of IT Systems.* Since interoperability of information technology (IT) systems is the most critical component of electronic communications that will be relied upon heavily during a public health emergency to transmit vital information, data, alerts and advisories, it is paramount that states make every effort to ensure this desired outcome. Describe what measures the state has taken to ensure the connectivity and interoperability, both vertically and horizontally, of its various IT systems with those of local health departments, hospitals, emergency management agencies, public safety agencies, neighboring states, federal public health officials and others.

*Border States.* Describe how State and local Health departments sharing an international border with Mexico or Canada foster collaboration and coordinate with border counties and existing border agencies and institutions. The traditional definition of the border is 100 kilometers on either side of the international boundary, but state and local public health agencies in consultation with local public health agencies serving the border areas may choose to define the border in a more functional way. States may use funds to conduct necessary actions in support of binational planning, coordination, program development, and contracting in Mexico or Canada if such actions directly contribute to health security in the United States. In all regional planning efforts, describe any collaborative efforts undertaken by local health departments with hospitals in their communities to develop an integrated regional approach to a mass casualty event.

## **ADDENDUM: NATIONAL INCIDENT MANAGEMENT SYSTEM**

On February 28, 2003, President Bush issued Homeland Security Presidential Directive/HSPD-5 establishing the National Incident Management System (NIMS). NIMS covers all incidents (natural and unnatural) for which the federal government deploys emergency response assets. The Secretary of Homeland Security is responsible for developing and maintaining NIMS.

Bioterrorism and other public health incidents fall within the scope of NIMS. To this end, the Department of Health and Human Services (DHHS) will have the initial lead responsibility for the federal government and will deploy assets as needed within the areas of his or her statutory responsibility (e.g., the Public Health Service Act and the



Federal Food Drug and Cosmetic Act) while keeping the Secretary of Homeland Security apprised regarding the course of the incident and the nature of the response operations.

HSPD-5 provides for the Department of Homeland Security (DHS) to assume responsibility for coordinating federal response operations under certain circumstances. In particular, “The Secretary shall coordinate the federal government’s resources utilized in response to or recovery from terrorist attacks, major disasters, or other emergencies if and when any one of the following four conditions applies: (1) a federal department or agency acting under its own authority has requested the assistance of the Secretary; (2) the resources of state and local authorities are overwhelmed and federal assistance has been formally requested by the state and local authorities; (3) more than one federal department or agency has become substantially involved in responding to the incident; or (4) the Secretary has been directed to assume responsibility for managing the domestic incident by the President.”

States will need incident management systems that are interoperable with NIMS if States and local governments are to gain full benefit from the emergency response assets of the federal government. To that end, HSPD-5 requires that, effective with Fiscal Year 2005 awards, adherence to and compatibility with NIMS be a condition of all grants and other awards from federal government agencies for any aspect of state or local emergency preparedness and response. DHHS has elected to begin the requisite planning activities immediately with a view to avoiding unnecessary and potentially costly revisions in Fiscal Year 2005 to DHHS-sponsored activities already underway or undertaken in Fiscal Years 2003 or 2004.